COMMONWEALTH OF KENTUCKY
OFFICE OF WORKERS CLAIMS
CLAIM NO. _____
BEFORE _____

_____ PLAINTIFF
(EMPLOYEE)

VS. **AFFIDAVIT FOR PAYMENT OF TEMPORARY TOTAL DISABILITY**

_____
DEFENDANT(S)
(EMPLOYER)

_____
(**OTHER DEFENDANTS)**

_____
(**SPECIAL FUND)**

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The undersigned, _____ after being duly sworn,
(NAME)

states that on _____, the undersigned sustained a work-related inju
(DATE)

_____
(BUSINESS LOCATION AND ADDRESS)

Notice was given on _____ to _____.
(DATE) **(PERSON AND POSITION)**

An employment relationship existed between the _____ and the
(EMPLOYEE)

employer in this action. My average weekly wage is $_____ and suppo
(AMOUNT OF WEEKLY WAGE)

documents are attached such as paycheck stub, W-2, etc.

Medical treatment was provided on _____ and given by _____
(DATE) **(MEDICAL PROVIDER &**

_____. The medical report of Dr.
MEDICAL PROVIDERS ADDRESS)

_____is attached to this affidavit and establishes the inability
(DOCTORS NAME)

to perform any work. Moreover, the employee states that irreparable injury as described below will occur

if payments of temporary total disability are not immediately started.

_____

_____

_____

_____

_____
(EMPLOYEE'S SIGNATURE)

Subscribed and sworn to before me by _____
(EMPLOYEE'S NAME)

on this the _____ day of _____ 20 _____.
(MONTH) **(DATE)** **(YEAR)**

_____
NOTARY PUBLIC

My Commission expires: _____ County: _____